104TH CONGRESS
1ST SESSION

# S. 18

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

JANUARY 4, 1995

Mr. SPECTER introduced the following bill; which was read twice and referred to the Committee on Finance

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# A BILL

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Assurance Act of 1995''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

# TITLE I—HEALTH CARE INSURANCE COVERAGE

## Subtitle A—Definitions

**SEC. 100. DEFINITIONS.**

For purposes of this title:

(1) DEPENDENT.—The term ''dependent'' means, with respect to any individual, any person who is—

(A) the spouse or surviving spouse of the individual; or

(B) under regulations of the Secretary, a child (including an adopted child) of such individual and—

(i) under 19 years of age; or

(ii) under 25 years of age and a full-time student.

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, an employee who normally performs on a monthly basis at least 30 hours of service per week for that employer.

(3) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means, with respect to an eligible employee, such employee, and any dependent of such employee.

(4) EMPLOYER.—The term ''employer'' shall have the meaning given such term in section 3(5) of the Employee Retirement Income Security Act of 1974.

(5) GROUP HEALTH PLAN.—The term ''group health plan'' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance plan under paragraph (6)(B).

(6) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance plan'' means any hospital or medical service

policy or certificate, hospital, or medical service plan contract, or health maintenance organization group contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following:

(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

(ii) Medicare supplemental health insurance.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Worker's compensation or similar insurance.

(v) Automobile medical-payment insurance.

(vi) Any combination of the insurance described in clauses (i) through (v).

(7) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency that offers to provide

health services on a prepaid, at-risk basis primarily through a defined set of providers.

(8) INSURER.—The term ''insurer'' means any person that offers a health insurance plan including—

(A) a licensed insurance company;

(B) a prepaid hospital or medical service plan;

(C) a health maintenance organization;

(D) a self-insurer carrier;

(E) a reinsurance carrier; and

(F) a multiple small employer welfare arrangement (a combination of small employers associated for the purpose of providing health insurance plan coverage for their employees).

(9) NAIC.—The term ''NAIC'' means the National Association of Insurance Commissioners.

(10) QUALIFIED HEALTH INSURANCE PLAN.—The term ''qualified health insurance plan'' shall have the meaning given such term in section 111(b).

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(12) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an employer that normally employs more than 1 but not

more than 50 eligible employees on a typical business day. For the purposes of this paragraph, the term ''employee'' includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

(13) STATE.—The term ''State'' means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

# Subtitle B—Increased Availability and Continuity of Health Coverage

## PART 1—REFORM OF HEALTH INSURANCE MARKETPLACE FOR SMALL EMPLOYERS

### Subpart A—Insurance Market Reform

#### SEC. 111. REQUIREMENT FOR INSURERS TO OFFER QUALIFIED HEALTH INSURANCE PLANS.

(a) REQUIREMENT TO OFFER.—Each insurer that makes available a health insurance plan to a small employer in a State shall make available to each small employer in the State a qualified health insurance plan (as defined in subsection (b)).

(b) QUALIFIED HEALTH INSURANCE PLAN.—The term ''qualified health insurance plan'' means a health insurance plan (whether a managed-care plan, indemnity

plan, or other plan) that is designed to provide standard coverage (consistent with section 112(b)).

(c) MARKETING REQUIREMENTS.—The requirements of subsection (a) are not met unless the plan described in subsection (a) is made available to small employers using at least the marketing methods and other sales practices which are used in selling other health insurance plans within the same class of business made available by the insurer.

**SEC. 112. ACTUARIAL EQUIVALENCE IN BENEFITS PERMITTED.**

(a) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

(1) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a set of rules which the NAIC determines is sufficient for determining, in the case of any health insurance plan and for purposes of this section, the actuarial value of the coverage offered by the plan.

(2) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules that comply with the requirements of paragraph (1), the Secretary shall certify such set of rules for use under this subtitle. If the Secretary determines that such a set of rules has not been submitted or does

not comply with such requirements, the Secretary shall promptly establish a set of rules that meets such requirements.

(b) STANDARD COVERAGE.—

(1) IN GENERAL.—A health insurance plan is considered to provide standard coverage consistent with this subsection if the benefits are determined, in accordance with the set of actuarial equivalence rules certified under subsection (a), to have a value that is within 5 percentage points of the target actuarial value for standard coverage established under paragraph (2).

(2) INITIAL DETERMINATION OF TARGET ACTUARIAL VALUE FOR STANDARD COVERAGE.—

(A) INITIAL DETERMINATION.—

(i) IN GENERAL.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a target actuarial value for standard coverage equal to the average actuarial value of the coverage described in clause (ii). No specific procedure or treatment, or classes thereof, is required to be considered in such determination by this Act or through regulations. The determina-

tion of such value shall be based on a representative distribution of the population of eligible employees offered such coverage and a single set of standardized utilization and cost factors.

(ii) COVERAGE DESCRIBED.—The coverage described in this clause is coverage for medically necessary and appropriate services consisting of medical and surgical services, medical equipment, preventive services, and emergency transportation in frontier areas. No specific procedure or treatment, or classes thereof, is required to be covered in such a plan, by this Act or through regulations.

(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a target actuarial value for standard coverage that complies with the requirements of subparagraph (A), the Secretary shall certify such value for use under this subtitle. If the Secretary determines that a target actuarial value has not been submitted or does not comply with the requirements of subparagraph (A), the Secretary shall

promptly determine a target actuarial value that meets such requirements.

(c) SUBSEQUENT REVISIONS.—

(1) NAIC.—The NAIC may submit from time to time to the Secretary revisions of the set of rules of actuarial equivalence and target actuarial values previously established or determined under this section if the NAIC determines that revisions are necessary to take into account changes in the relevant types of health benefits provisions or in demographic conditions which form the basis for the set of rules of actuarial equivalence or the target actuarial values. The provisions of subsection (a)(2) shall apply to such a revision in the same manner as they apply to the initial determination of the set of rules.

(2) SECRETARY.—The Secretary may by regulation revise the set of rules of actuarial equivalence and target actuarial values from time to time if the Secretary determines such revisions are necessary to take into account changes described in paragraph (1).

**SEC. 113. ESTABLISHMENT OF HEALTH INSURANCE PLAN STANDARDS.**

(a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The NAIC is requested to submit to the Secretary, within 9 months after the date of the enactment of this Act, model regulations that specify standards with respect to the requirement, under section 111(a), that insurers make available qualified health insurance plans. If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirement under section 111(a), such standards shall serve as the standards under this section, with such amendments as the Secretary deems necessary.

(2) CONTINGENCY.—If the NAIC does not develop such model regulations within the period described in paragraph (1), or the Secretary determines that such regulations do not specify standards that meet the requirement under section 111(a), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out such requirement.

(3) EFFECTIVE DATE.—The standards specified in the model regulations shall apply to health insurance plans in a State on or after the respective date the standards are implemented in the State under subsection (b).

(4) NO PREEMPTION OF STATE LAW.—A State may implement standards for health insurance plans made available to small employers that are more stringent than the requirements under this section, except that a State may not implement standards that prevent the offering by an insurer of at least one health insurance plan that provides standard coverage (as described in section 112(b)).

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in paragraph (2), a report on the steps the State is taking to implement and enforce the standards with respect to insurers, and qualified health insurance plans offered, not later than such deadline.

(2) DEADLINE FOR REPORT.—

(A) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to subparagraph (B), the deadline under this paragraph is 1 year after

the date the standards are established under subsection (a).

(B) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for insurers and qualified health insurance plans offered to meet the standards established under subsection (a), but

(ii) having a legislature which is not scheduled to meet in 1997 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1998. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(3) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by

the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the standards under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit the report or to implement and enforce the standards. If, after that 60-day period, the Secretary finds that the failure has not been corrected, the Secretary shall provide for the implementation and enforcement of the standards in the State in such a way as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to insurers and qualified health insurance plans offered or renewed on or after 3 months after the date of the Secretary's finding under the previous sentence and until the date the Secretary finds that such a failure has been corrected.

**Subpart B—Additional Standards for Health Insurance Plans Offered to Small Employers**

**SEC. 121. GENERAL ISSUANCE REQUIREMENTS.**

(a) GENERAL RULE.—Any insurer offering a health insurance plan to a small employer shall meet the following requirements:

(1) The guaranteed issue requirements of subsection (b).

(2) The mandatory registration and disclosure requirements of subsection (c).

(b) GUARANTEED ISSUE.—

(1) IN GENERAL.—The requirements of this subsection are met if the insurer offering a health insurance plan to small employers in the State—

(A) accepts every small employer in the State that applies for coverage under the plan; and

(B) accepts for enrollment under the plan every eligible individual who applies for enrollment on a timely basis (consistent with paragraph (3)).

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of a plan offered by a health maintenance organization, the plan may—

(A) limit the employers that may apply for coverage to those with eligible individuals residing in the service area of the plan;

(B) limit the individuals who may be enrolled under the plan to those who reside in the service area of the plan; and

(C) within the service area of the plan, deny coverage to such employers if the plan demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

(ii) it is applying this subparagraph uniformly to all employers without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

(3) CLARIFICATION OF TIMELY ENROLLMENT.—

(A) GENERAL INITIAL ENROLLMENT REQUIREMENT.—Except as provided in this paragraph, a health insurance plan may consider enrollment of an eligible individual not to be timely if the eligible employee or dependent fails to enroll in the plan during an initial enrollment period, if such period is at least 30 days long.

(B) ENROLLMENT DUE TO LOSS OF PREVIOUS EMPLOYER COVERAGE.—Enrollment in a

health insurance plan is considered to be timely in the case of an eligible individual who—

(i) was covered under another health insurance plan or group health plan at the time of the individual's initial enrollment period;

(ii) stated at the time of the initial enrollment period that coverage under a health insurance plan or a group health plan was the reason for declining enrollment;

(iii) lost coverage under another health insurance plan or group health plan (as a result of the termination of the other plan's coverage, termination or reduction of employment, or other reason); and

(iv) requests enrollment within 30 days after termination of such coverage.

(C) REQUIREMENT APPLIES DURING OPEN ENROLLMENT PERIODS.—Each health insurance plan shall provide for at least one period (of not less than 30 days) each year during which enrollment under the plan shall be considered to be timely.

(D) EXCEPTION FOR COURT ORDERS.—Enrollment of a spouse or minor child of an employee shall be considered to be timely if—

(i) a court has ordered that coverage be provided for the spouse or child under a covered employee's group health plan; and

(ii) a request for enrollment is made within 30 days after the date the court issues the order.

(E) ENROLLMENT OF SPOUSES AND DEPENDENTS.—

(i) IN GENERAL.—Enrollment of the spouse (including a child of the spouse) and any dependent child of an eligible employee shall be considered to be timely if a request for enrollment is made either—

(I) within 30 days of the date of the marriage or of the date of the birth or adoption of a child, if family coverage is available as of such date; or

(II) within 30 days of the date family coverage is first made available.

(ii) COVERAGE.—If a plan makes family coverage available and enrollment is made under the plan on a timely basis under clause (i)(I), the coverage shall become effective not later than the first day of the first month beginning after the date of the marriage or the date of birth or adoption of the child (as the case may be).

(4) FINANCIAL CAPACITY EXCEPTION.—Paragraph (1) shall not require any insurer to issue a health insurance plan to the extent that the issuance of such plan would result in such insurer violating the financial solvency standards (if any) established by the State in which such plan is to be issued.

(5) DELIVERY CAPACITY EXCEPTION.—

(A) IN GENERAL.—Paragraph (1) shall not prohibit an insurer from ceasing enrollment under a health insurance plan if—

(i) the insurer ceases to enroll any new small employers under the plan; and

(ii) the insurer can demonstrate to the Secretary that its provider capacity to serve previously covered groups or individuals (and additional individuals who will be expected to enroll because of affiliation

with such previously covered groups or individuals) will be impaired if it is required to enroll other small employers.

(B) FIRST-COME-FIRST-SERVED.—An insurer is only eligible to exercise the exceptions provided for in subparagraph (A) if such insurer provides for enrollment on a first-come-first-served basis (except in the case of additional individuals described in subparagraph (A)(ii)).

(6) ADDITIONAL EXCEPTIONS.—Paragraph (1) shall not apply to a failure to issue a health insurance plan to a small employer if—

(A) such employer is unable to pay the premium for such contract; or

(B) in the case of a small employer with fewer than 15 employees, such employer fails to enroll a minimum percentage of the employer's employees for coverage under such plan, so long as such percentage is enforced uniformly for all small employers of comparable size.

(7) EXCEPTION FOR ALTERNATIVE STATE PROGRAMS.—

(A) IN GENERAL.—Paragraph (1) shall not apply if the State in which the health insurance plan is issued—

(i) has a program which—

(I) assures the availability of health insurance plans to small employers through the equitable distribution of high risk groups among all insurers offering such contracts to such small employers; and

(II) is consistent with a model program developed by the NAIC;

(ii) has a qualified State-run reinsurance program; or

(iii) has a program which the Secretary has determined assures all small employers in the State an opportunity to purchase a health insurance plan without regard to any risk characteristic.

(B) REINSURANCE PROGRAM.—

(i) PROGRAM REQUIREMENTS.—For purposes of subparagraph (A)(ii), a State-run reinsurance program is qualified if such program is one of the NAIC reinsurance program models developed under

clause (ii) or is a variation of one of such models, as approved by the Secretary.

(ii) MODELS.—Not later than 120 days after the date of the enactment of this Act, the NAIC shall develop several models for a reinsurance program, including options for program funding.

(c) MANDATORY REGISTRATION REQUIREMENTS.—The requirements of this subsection are met if the insurer offering health insurance plans to small employers in any State registers with the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance.

**SEC. 122. RATING LIMITATIONS FOR COMMUNITY-RATED MARKET.**

(a) STANDARD PREMIUMS WITH RESPECT TO COMMUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Each health insurance plan offered to a small employer shall establish within each community rating area in which the plan is to be offered, a standard premium for enrollment of eligible employees and eligible individuals for the standard coverage (as defined under section 112(b)).

(2) ESTABLISHMENT OF COMMUNITY RATING AREA.—

(A) IN GENERAL.—Not later than January 1, 1996, each State shall, in accordance with subparagraph (B), provide for the division of the State into 1 or more community rating areas. The State may revise the boundaries of such areas from time to time consistent with this paragraph.

(B) GEOGRAPHIC AREA VARIATIONS.—For purposes of subparagraph (A), a State—

(i) may not identify an area that divides a 3-digit zip code, a county, or all portions of a metropolitan statistical area;

(ii) shall not permit premium rates for coverage offered in a portion of an interstate metropolitan statistical area to vary based on the State in which the coverage is offered; and

(iii) may, upon agreement with one or more adjacent States, identify multi-State geographic areas consistent with clauses (i) and (ii).

(3) ELIGIBLE INDIVIDUALS.—For purposes of this section, the term ''eligible individuals'' includes

certain uninsured individuals (as described in section 133).

(b) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the standard premium for each health insurance plan shall be the same, but shall not include the costs of premium processing and enrollment that may vary depending on whether the method of enrollment is through a qualified small employer purchasing group (established under subpart C), through a small employer, or through a broker.

(2) APPLICATION TO ENROLLEES.—

(A) IN GENERAL.—The premium charged for coverage in a health insurance plan which covers eligible employees and eligible individuals shall be the product of—

(i) the standard premium (established under paragraph (1));

(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

(iii) the age adjustment factor (specified under subparagraph (C)).

(B) FAMILY ADJUSTMENT FACTOR.—

(i) IN GENERAL.—The standards established under section 113 shall specify family adjustment factors that reflect the relative actuarial costs of benefit packages based on family classes of enrollment (as compared with such costs for individual enrollment).

(ii) CLASSES OF ENROLLMENT.—For purposes of this Act, there are 4 classes of enrollment:

(I) Coverage only of an individual (referred to in this Act as the ''individual'' enrollment or class of enrollment).

(II) Coverage of a married couple without children (referred to in this Act as the ''couple-only'' enrollment or class of enrollment).

(III) Coverage of an individual and one or more children (referred to in this Act as the ''single parent'' enrollment or class of enrollment).

(IV) Coverage of a married couple and one or more children (referred

to in this Act as the ''dual parent'' enrollment or class of enrollment).

(iii) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this subtitle:

(I) FAMILY.—The terms ''family enrollment'' and ''family class of enrollment'' refer to enrollment in a class of enrollment described in any subclause of clause (ii) (other than subclause (I)).

(II) COUPLE.—The term ''couple class of enrollment'' refers to enrollment in a class of enrollment described in subclause (II) or (IV) of clause (ii).

(iv) SPOUSE; MARRIED; COUPLE.—

(I) IN GENERAL.—In this subtitle, the terms ''spouse'' and ''married'' mean, with respect to an individual, another individual who is the spouse of, or is married to, the individual, as determined under applicable State law.

(II) COUPLE.—The term ''couple'' means an individual and the individual's spouse.

(C) AGE ADJUSTMENT FACTOR.—The Secretary, in consultation with the NAIC, shall specify uniform age categories and maximum rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed 3 times the lowest age adjustment factor.

(3) ADMINISTRATIVE CHARGES.—

(A) IN GENERAL.—In accordance with the standards established under section 113, a health insurance plan which covers eligible employees and eligible individuals may add a separately-stated administrative charge which is based on identifiable differences in legitimate administrative costs and which is applied uniformly for individuals enrolling through the same method of enrollment. Nothing in this subparagraph may be construed as preventing a qualified small employer purchasing group from

negotiating a unique administrative charge with an insurer for a health insurance plan.

(B) ENROLLMENT THROUGH A QUALIFIED SMALL EMPLOYER PURCHASING GROUP.—In the case of an administrative charge under subparagraph (A) for enrollment through a qualified small employer purchasing group, such charge may not exceed the lowest charge of such plan for enrollment other than through a qualified small employer purchasing group in such area.

(c) TREATMENT OF NEGOTIATED RATE AS COMMUNITY RATE.—Notwithstanding any other provision of this section, an insurer which negotiates a premium rate (exclusive of any administrative charge described in subsection (b)(3)) with a qualified small employer purchasing group in a community rating area shall charge the same premium rate to all eligible employees and eligible individuals.

**SEC. 123. RATING PRACTICES AND PAYMENT OF PREMIUMS.**

(a) FULL DISCLOSURE OF RATING PRACTICES.—

(1) IN GENERAL.—An insurer shall fully disclose rating practices for such plan to the appropriate certifying authority (as determined under section 121(c)).

(2) NOTICE ON EXPIRATION.—An insurer shall provide for notice of the terms for renewal of a health insurance plan at the time of the offering of the plan and at least 90 days before the date of expiration of the plan.

(3) ACTUARIAL CERTIFICATION.—Each insurer shall file annually with the appropriate certifying authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such authority) who is not an employee of the insurer certifying that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of such insurer and methods used by the insurer in establishing premium rates and administrative charges for health insurance plans—

(A) such insurer is in compliance with the applicable provisions of this subtitle; and

(B) the rating methods are actuarially sound.

Each insurer shall retain a copy of such statement at its principal place of business for examination by any individual.

(b) PAYMENT OF PREMIUMS.—

(1) IN GENERAL.—With respect to a new enrollee in a health insurance plan, the plan may require advanced payment of an amount equal to the monthly applicable premium for the plan at the time such individual is enrolled.

(2) NOTIFICATION OF FAILURE TO RECEIVE PREMIUM.—If a health insurance plan fails to receive payment on a premium due with respect to an eligible employee or eligible individual covered under the plan, the plan shall provide notice of such failure to the employee or individual within the 20-day period after the date on which such premium payment was due. A plan may not terminate the enrollment of an eligible employee or eligible individual unless such employee or individual has been notified of any overdue premiums and has been provided a reasonable opportunity to respond to such notice.

## Subpart C—Small Employer Purchasing Groups

### SEC. 131. QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

(a) QUALIFIED SMALL EMPLOYER PURCHASING GROUPS DESCRIBED.—

(1) IN GENERAL.—A qualified small employer purchasing group is an entity that—

(A) is a nonprofit entity certified under State law;

(B) has a membership consisting solely of small employers;

(C) is administered solely under the authority and control of its member employers;

(D) with respect to each State in which its members are located, consists of not fewer than the number of small employers established by the State as appropriate for such a group;

(E) offers a program under which qualified health insurance plans are offered to eligible employees and eligible individuals through its member employers and to certain uninsured individuals in accordance with section 122; and

(F) an insurer, agent, broker, or any other individual or entity engaged in the sale of insurance—

(i) does not form or underwrite; and

(ii) does not hold or control any right to vote with respect to.

(2) STATE CERTIFICATION.—A qualified small employer purchasing group formed under this section shall submit an application to the State for certification. The State shall determine whether to

issue a certification and otherwise ensure compliance with the requirements of this Act.

(3) SPECIAL RULE.—Notwithstanding paragraph (1)(B), an employer member of a small employer purchasing group that has been certified by the State as meeting the requirements of paragraph (1) may retain its membership in the group if the number of employees of the employer increases such that the employer is no longer a small employer.

(b) BOARD OF DIRECTORS.—Each qualified small employer purchasing group established under this section shall be governed by a board of directors or have active input from an advisory board consisting of individuals and businesses participating in the group.

(c) DOMICILIARY STATE.—For purposes of this section, a qualified small employer purchasing group operating in more than one State shall be certified by the State in which the group is domiciled.

(d) MEMBERSHIP.—

(1) IN GENERAL.—A qualified small employer purchasing group shall accept all small employers and certain uninsured individuals residing within the area served by the group as members if such employers or individuals request such membership.

(2) VOTING.—Members of a qualified small employer purchasing group shall have voting rights consistent with the rules established by the State.

(e) DUTIES OF QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.—Each qualified small employer purchasing group shall—

(1) enter into agreements with insurers offering qualified health insurance plans;

(2) enter into agreements with small employers under section 132;

(3) enroll only eligible employees, eligible individuals, and certain uninsured individuals in qualified health insurance plans, in accordance with section 133;

(4) provide enrollee information to the State;

(5) meet the marketing requirements under section 135; and

(6) carry out other functions provided for under this Act.

(f) LIMITATION ON ACTIVITIES.—A qualified small employer purchasing group shall not—

(1) perform any activity involving approval or enforcement of payment rates for providers;

(2) perform any activity (other than the reporting of noncompliance) relating to compliance of

qualified health insurance plans with the requirements of this Act;

(3) assume financial risk in relation to any such health plan; or

(4) perform other activities identified by the State as being inconsistent with the performance of its duties under this Act.

(g) RULES OF CONSTRUCTION.—

(1) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

(A) that a State organize, operate or otherwise establish a qualified small employer purchasing group, or otherwise require the establishment of purchasing groups; and

(B) that there be only one qualified small employer purchasing group established with respect to a community rating area.

(2) SINGLE ORGANIZATION SERVING MULTIPLE AREAS AND STATES.—Nothing in this section shall be construed as preventing a single entity from being a qualified small employer purchasing group in more than one community rating area or in more than one State.

(3) VOLUNTARY PARTICIPATION.—Nothing in this section shall be construed as requiring any indi-

vidual or small employer to purchase a qualified health insurance plan exclusively through a qualified small employer purchasing group.

**SEC. 132. AGREEMENTS WITH SMALL EMPLOYERS.**

(a) IN GENERAL.—A qualified small employer purchasing group shall offer to enter into an agreement under this section with each small employer that employs eligible employees in the area served by the group.

(b) PAYROLL DEDUCTION.—

(1) IN GENERAL.—Under an agreement under this section between a small employer and a qualified small employer purchasing group, the small employer shall deduct premiums from an eligible employee's wages.

(2) ADDITIONAL PREMIUMS.—If the amount withheld under paragraph (1) is not sufficient to cover the entire cost of the premiums, the eligible employee shall be responsible for paying directly to the qualified small employer purchasing group the difference between the amount of such premiums and the amount withheld.

**SEC. 133. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE INDIVIDUALS, AND CERTAIN UNINSURED INDIVIDUALS IN QUALIFIED HEALTH INSURANCE PLANS.**

(a) IN GENERAL.—Each qualified small employer purchasing group shall offer—

(1) eligible employees,

(2) eligible individuals, and

(3) certain uninsured individuals,

the opportunity to enroll in any qualified health insurance plan which has an agreement with the qualified small employer purchasing group for the community rating area in which such employees and individuals reside.

(b) UNINSURED INDIVIDUALS.—For purposes of this section, an individual is described in subsection (a)(3) if such individual is an uninsured individual who is not an eligible employee of a small employer that is a member of a qualified small employer purchasing group or a dependent of such individual.

**SEC. 134. RECEIPT OF PREMIUMS.**

(a) ENROLLMENT CHARGE.—The amount charged by a qualified small employer purchasing group for coverage under a qualified health insurance plan shall be equal to the sum of—

(1) the premium rate offered by such health plan;

(2) the administrative charge for such health plan; and

(3) the purchasing group administrative charge for enrollment of eligible employees, eligible individuals and certain uninsured individuals through the group.

(b) DISCLOSURE OF PREMIUM RATES AND ADMINISTRATIVE CHARGES.—Each qualified small employer purchasing group shall, prior to the time of enrollment, disclose to enrollees and other interested parties the premium rate for a qualified health insurance plan, the administrative charge for such plan, and the administrative charge of the group, separately.

**SEC. 135. MARKETING ACTIVITIES.**

Each qualified small employer purchasing group shall market qualified health insurance plans to members through the entire community rating area served by the purchasing group.

**SEC. 136. GRANTS TO STATES AND QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.**

(a) IN GENERAL.—The Secretary shall award grants to States and small employer purchasing groups to assist such States and groups in planning, developing, and operating qualified small employer purchasing groups.

(b) APPLICATION REQUIREMENTS.—To be eligible to receive a grant under this section, a State or small employer purchasing group shall prepare and submit to the Secretary an application in such form, at such time, and containing such information, certifications, and assurances as the Secretary shall reasonably require.

(c) USE OF FUNDS.—Amounts awarded under this section may be used to finance the costs associated with planning, developing, and operating a qualified small employer purchasing group. Such costs may include the costs associated with—

(1) engaging in education and outreach efforts to inform small employers, insurers, and the public about the small employer purchasing group;

(2) soliciting bids and negotiating with insurers to make available health care benefit plans;

(3) preparing the documentation required to receive certification by the Secretary as a qualified small employer purchasing group; and

(4) such other activities determined appropriate by the Secretary.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for awarding grants under this subsection such sums as may be necessary.

**SEC. 137. QUALIFIED SMALL EMPLOYER PURCHASING GROUPS ESTABLISHED BY A STATE.**

A State may establish a system in all or part of the State under which qualified small employer purchasing groups are the sole mechanism through which health care coverage for the eligible employees of small employers shall be purchased or provided.

## PART 2—STANDARDS APPLICABLE TO ALL HEALTH INSURANCE PLANS

**SEC. 141. COVERAGE REQUIREMENTS.**

(a) GENERAL RULE.—Any insurer offering a health insurance plan shall meet the coverage requirements of subsection (b).

(b) COVERAGE REQUIREMENTS.—

(1) IN GENERAL.—The requirements of this subsection are met with respect to any health insurance plan if, under the terms and operation of the plan, the following requirements are met:

(A) GUARANTEED ELIGIBILITY.—No individual (and any dependent of the individual eligible for coverage) may be denied, limited, conditioned, or excluded from coverage under (or benefits of) the plan for any reason, including health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care expenses, disabil-

ity, or lack of evidence of insurability, of the individual.

(B) LIMITATIONS ON COVERAGE OF PRE-EXISTING CONDITIONS.—Any limitation under the plan on any preexisting condition—

(i) may not extend beyond the 6-month period beginning with the date an insured is first covered by the plan;

(ii) may only apply to preexisting conditions which manifested themselves, or for which medical care or advice was sought or recommended, during the 3-month period preceding the date an insured is first covered by the plan;

(iii) may not extend to an individual who, as of the date of birth, was covered under the plan; and

(iv) may not relate to pregnancy.

(C) GUARANTEED RENEWABILITY.—

(i) IN GENERAL.—The plan must be renewed at the election of the insured unless the plan is terminated for cause.

(ii) CAUSE.—For purposes of this subparagraph, the term ''cause'' means—

(I) nonpayment of the required premiums;

(II) fraud or misrepresentation of the insured or their representatives;

(III) noncompliance with the plan's minimum participation requirements;

(IV) noncompliance with the plan's employer contribution requirements; or

(V) repeated misuse of a provider network provision in the plan.

(2) WAITING PERIODS.—Paragraph (1)(A) shall not apply to any period an employee is excluded from coverage under the plan solely by reason of a requirement applicable to all employees that a minimum period of service with the employer is required before the employee is eligible for such coverage.

(3) DETERMINATION OF PERIODS FOR RULES RELATING TO PREEXISTING CONDITIONS.—For purposes of paragraph (1)(B), the date on which an insured is first covered by a plan shall be the earlier of—

(A) the date on which coverage under such plan begins; or

(B) the first day of any continuous period—

(i) during which the insured was covered under one or more other health insurance arrangements; and

(ii) in the case of an employee, which does not end more than 120 days before the date employment with the employer begins.

(4) CESSATION OF BUSINESS.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, an insurer shall not be treated as failing to meet the requirements of paragraph (1)(C) if such insurer terminates the class of business which includes the health insurance plan.

(B) NOTICE REQUIREMENT.—Subparagraph (A) shall apply only if the insurer gives notice of the decision to terminate at least 90 days before the expiration of the plan.

(C) 5-YEAR MORATORIUM.—If, within 5 years of the year in which an insurer terminates a class of business under subparagraph (A), such insurer establishes a new class of business,

the issuance of plans in that year shall be treated as a failure to which this section applies.

(D) TRANSFERS.—If, upon a failure to renew a plan to which subparagraph (A) applies, an insurer offers to transfer such plan to another class of business, such transfer must be made without regard to risk characteristics.

(5) CLASS OF BUSINESS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''class of business'' means, with respect to health care insurance provided to persons, all health care insurance provided to such persons.

(B) ESTABLISHMENT OF GROUPINGS.—

(i) IN GENERAL.—An issuer may establish separate classes of business with respect to health care insurance provided to all persons but only if such classes are based on one or more of the following:

(I) Business marketed and sold through insurers not participating in the marketing and sale of such insurance to other persons.

(II) Business acquired from other insurers as a distinct grouping.

(III) Business provided through an association of not less than 20 small employers which was established for purposes other than obtaining insurance.

(IV) Business related to managed care plans.

(V) Any other business which the Secretary determines needs to be separately grouped to prevent a substantial threat to the solvency of the insurer.

(ii) EXCEPTION ALLOWED.—Except as provided in subparagraph (C), an insurer may not establish more than one distinct group of persons for each category specified in clause (i).

(C) SPECIAL RULE.—An insurer may establish up to 2 groups under each category in subparagraph (A) or (B) to account for differences in characteristics (other than differences in plan benefits) of health insurance plans that are expected to produce substantial variation in health care costs.

## PART 3—ENFORCEMENT OF STANDARDS FOR HEALTH INSURANCE PLANS

### SEC. 151. ENFORCEMENT BY EXCISE TAX ON INSURERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end the following new section:

### "SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH CERTAIN STANDARDS FOR HEALTH INSURANCE PLANS.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer to comply with the requirements applicable to such insurer under parts 1 and 2 of subtitle B of title I of the Health Care Assurance Act of 1995.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by an insurer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure

persists for each person to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

''(2) LIMITATION.—The amount of the tax imposed by subsection (a) for an insurer with respect to a health insurance plan shall not exceed 25 percent of the amounts received under the plan for coverage during the period such failure persists.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the insurer.

''(d) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the first date the insurer knows, or exercising reasonable diligence could have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all

of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance plan' and 'insurer' have the meanings given such terms in section 100 of the Health Care Assurance Act of 1995.''.

(b) CLERICAL AMENDMENT.—The table of sections for such chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Failure of insurer to comply with certain standards for health insurance plans.''.

## PART 4—EFFECTIVE DATES

### SEC. 161. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in this subtitle, the provisions of this subtitle are effective on the date of the enactment of this Act.

(b) EXCEPTION.—The provisions of section 121(b) shall apply to contracts which are issued, or renewed, after the date which is 18 months after the date of the enactment of this Act.

# Subtitle C—Required Coverage Options for Eligible Employees and Dependents of Small Employers

## SEC. 171. REQUIRING SMALL EMPLOYERS TO OFFER COVERAGE FOR ELIGIBLE INDIVIDUALS.

(a) REQUIREMENT TO OFFER.—Each small employer shall make available with respect to each eligible employee a group health plan under which—

(1) coverage of each eligible individual with respect to such an eligible employee may be elected on an annual basis for each plan year;

(2) coverage is provided for at least the standard coverage specified in section 112(b); and

(3) each eligible employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An employer is not required under subsection (a) to make any contribution to the cost of coverage under a group health plan described in such subsection.

(c) SPECIAL RULES.—

(1) EXCLUSION OF NEW EMPLOYERS AND CERTAIN VERY SMALL EMPLOYERS.—Subsection (a) shall not apply to any small employer for any plan year if, as of the beginning of such plan year—

(A) such employer (including any predecessor thereof) has been an employer for less than 2 years;

(B) such employer has no more than 2 eligible employees; or

(C) no more than 2 eligible employees are not covered under any group health plan.

(2) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of a small employer may be, at the election of the employer, excluded from consideration as an eligible employee for purposes of applying the requirements of subsection (a). In the case of a small employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludable under this paragraph.

(3) OPTIONAL APPLICATION OF WAITING PERIOD.—A group health plan shall not be treated as failing to meet the requirements of subsection (a) solely because a period of service by an eligible employee of not more than 60 days is required under

the plan for coverage under the plan of eligible individuals with respect to such employee.

(d) CONSTRUCTION.—Nothing in this section shall be construed as limiting the group health plans, or types of coverage under such a plan, that an employer may offer to an employee.

**SEC. 172. COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.**

(a) IN GENERAL.—In any case in which an eligible employee is, for any plan year, a participant in a group health plan which is a multiemployer plan, the requirements of section 171(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (b) are met with respect to the eligible employee, irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

(b) EMPLOYER REQUIREMENTS.—The employer requirements of this subsection are met under a plan with respect to an eligible employee if—

(1) the employee is eligible under the plan to elect coverage on an annual basis and is provided a reasonable opportunity to make the election in such

form and manner and at such times as are provided by the plan;

(2) coverage is provided for at least the standard coverage specified in section 112(b);

(3) the employer facilitates collection of any employee contributions under the plan and permits the employee to elect to have employee contributions under the plan collected through payroll deduction; and

(4) in the case of a plan to which part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 does not otherwise apply, the employer provides to the employee a summary plan description described in section 102(a)(1) of such Act in the form and manner and at such times as are required under such part 1 with respect to employee welfare benefit plans.

**SEC. 173. ENFORCEMENT BY EXCISE TAX ON SMALL EMPLOYERS.**

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to excise taxes on certain group health plans) is amended by inserting after section 5000 the following new section:

**"SEC. 5000A. SMALL EMPLOYER REQUIREMENTS.**

''(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any small employer to comply with the requirements of subtitle C of title I of the Health Care Assurance Act of 1995.

''(b) AMOUNT OF TAX.—The amount of tax imposed by subsection (a) shall be equal to $100 for each day for each individual for which such a failure occurs.

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the 1st date any of the individuals on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent

that the payment of such tax would be excessive relative to the failure involved.''.

(b) CLERICAL AMENDMENT.—The table of sections for such chapter 47 is amended by adding at the end the following new item:

''Sec. 5000A. Small employer requirements.''.

# Subtitle D—Required Coverage Options for Individuals Insured Through Association Plans

## PART 1—QUALIFIED ASSOCIATION PLANS

### SEC. 181. TREATMENT OF QUALIFIED ASSOCIATION PLANS.

(a) GENERAL RULE.—For purposes of this subtitle, in the case of a qualified association plan—

(1) except as otherwise provided in this part, the plan shall meet all applicable requirements of subpart A of part 1 and part 2 of subtitle B and subtitle C for group health plans offered to and by small employers;

(2) if such plan is certified as meeting such requirements and the requirements of this part, such plan shall be treated as a plan established and maintained by a small employer, and individuals enrolled in such plan shall be treated as eligible employees; and

(3) any individual who is a member of the association not enrolling in the plan shall not be treated

as an eligible employee solely by reason of membership in such association.

(b) ELECTION TO BE TREATED AS PURCHASING COOPERATIVE.—Subsection (a) shall not apply to a qualified association plan if—

(1) the health plan sponsor makes an irrevocable election to be treated as a qualified small employer purchasing group for purposes of subpart C of subtitle B; and

(2) such sponsor meets all requirements of this title applicable to a purchasing cooperative.

**SEC. 182. QUALIFIED ASSOCIATION PLAN DEFINED.**

(a) GENERAL RULE.—For purposes of this part, a plan is a qualified association plan if the plan is a multiple employer welfare arrangement or similar arrangement—

(1) which is maintained by a qualified association;

(2) which has at least 500 participants in the United States;

(3) under which the benefits provided consist solely of medical care (as defined in section 213(d) of the Internal Revenue Code of 1986);

(4) which may not condition participation in the plan, or terminate coverage under the plan, on the

basis of the health status or health claims experience of any employee or member or dependent of either;

(5) which provides for bonding, in accordance with regulations providing rules similar to the rules under section 412 of the Employee Retirement Income Security Act of 1974, of all persons operating or administering the plan or involved in the financial affairs of the plan; and

(6) which notifies each participant or provider that it is certified as meeting the requirements of this subtitle applicable to it.

(b) SELF-INSURED PLANS.—In the case of a plan which is not fully insured (within the meaning of section 514(b)(6)(D) of the Employee Retirement Income Security Act of 1974), the plan shall be treated as a qualified association plan only if—

(1) the plan meets minimum financial solvency and cash reserve requirements for claims which are established by the Secretary of Labor and which shall be in lieu of any other such requirements under this subtitle;

(2) the plan provides an annual funding report (certified by an independent actuary) and annual financial statements to the Secretary of Labor and other interested parties; and

(3) the plan appoints a plan sponsor who is responsible for operating the plan and ensuring compliance with applicable Federal and State laws.

(c) CERTIFICATION.—

(1) IN GENERAL.—A plan shall not be treated as a qualified association plan for any period unless there is in effect a certification by the Secretary of Labor that the plan meets the requirements of this part. For purposes of this subtitle, the Secretary of Labor shall be the appropriate certifying authority with respect to the plan.

(2) FEE.—The Secretary of Labor shall require a $5,000 fee for the original certification under paragraph (1) and may charge a reasonable annual fee to cover the costs of processing and reviewing the annual statements of the plan.

(3) EXPEDITED PROCEDURES.—The Secretary of Labor may by regulation provide for expedited registration, certification, and comment procedures.

(4) AGREEMENTS.—The Secretary of Labor may enter into agreements with the States to carry out the Secretary's responsibilities under this part.

(d) AVAILABILITY.—Notwithstanding any other provision of this subtitle, a qualified association plan may limit coverage to individuals who are members of the

qualified association establishing or maintaining the plan, an employee of such member, or a dependent of either.

(e) SPECIAL RULES FOR EXISTING PLANS.—In the case of a plan in existence on January 1, 1995—

(1) the requirements of subsection (a) (other than paragraph (4), (5), and (6) thereof) shall not apply;

(2) no original certification shall be required under this part; and

(3) no annual report or funding statement shall be required before January 1, 1997, but the plan shall file with the Secretary of Labor a description of the plan and the name of the plan sponsor.

**SEC. 183. DEFINITIONS AND SPECIAL RULES.**

(a) QUALIFIED ASSOCIATION.—For purposes of this part, the term ''qualified association'' means any organization which—

(1) is organized and maintained in good faith by a trade association, an industry association, a professional association, a chamber of commerce, a religious organization, a public entity association, or other business association serving a common or similar industry;

(2) is organized and maintained for substantial purposes other than to provide a health plan;

(3) has a constitution, bylaws, or other similar governing document which states its purpose; and

(4) receives a substantial portion of its financial support from its active, affiliated, or federation members.

(b) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—For purposes of this subchapter, the term ''multiple employer welfare arrangement'' has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974.

(c) COORDINATION WITH PART 2.—The term ''qualified association plan'' shall not include a plan to which part 2 applies.

## PART 2—SPECIAL RULE FOR CHURCH, MULTIEMPLOYER, AND COOPERATIVE PLANS

### SEC. 191. SPECIAL RULE FOR CHURCH, MULTIEMPLOYER, AND COOPERATIVE PLANS.

(a) GENERAL RULE.—For purposes of this subtitle, in the case of a group health plan to which this section applies—

(1) except as otherwise provided in this part, the plan shall be required to meet all applicable requirements of subpart A of part 1 and part 2 of subtitle B and subtitle C for group health plans offered to and by small employers;

(2) if such plan is certified as meeting such requirements, such plan shall be treated as a plan established and maintained by a small employer and individuals enrolled in such plan shall be treated as eligible employees; and

(3) any individual eligible to enroll in the plan who does not enroll in the plan shall not be treated as an eligible employee solely by reason of being eligible to enroll in the plan.

(b) MODIFIED STANDARDS.—

(1) CERTIFYING AUTHORITY.—For purposes of this subtitle, the Secretary of Labor shall be the appropriate certifying authority with respect to a plan to which this section applies.

(2) AVAILABILITY.—Rules similar to the rules of subsection (e) of section 182 shall apply to a plan to which this section applies.

(3) ACCESS.—An employer which, pursuant to a collective bargaining agreement, offers an employee the opportunity to enroll in a plan described in subsection (c)(2) shall not be required to make any other plan available to the employee.

(4) TREATMENT UNDER STATE LAWS.—A church plan described in subsection (c)(1) which is certified as meeting the requirements of this section

shall not be deemed to be a multiple employer welfare arrangement or an insurance company or other insurer, or to be engaged in the business of insurance, for purposes of any State law purporting to regulate insurance companies or insurance contracts.

(c) PLANS TO WHICH SECTION APPLIES.—This section shall apply to a health plan which—

(1) is a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986) which has at least 100 participants in the United States;

(2) is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974) which is maintained by a health plan sponsor described in section 3(16)(B)(iii) of such Act and which has at least 500 participants in the United States; or

(3) is a plan which is maintained by a rural electric cooperative or a rural telephone cooperative association (within the meaning of section 3(40) of such Act) and which has at least 500 participants in the United States.

## PART 3—ENFORCEMENT

### SEC. 1001. ENFORCEMENT BY EXCISE TAX ON QUALIFIED ASSOCIATIONS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans), as amended by section 151, is amended by adding at the end the following new section:

### "SEC. 4980D. FAILURE OF QUALIFIED ASSOCIATIONS, ETC., TO COMPLY WITH CERTAIN STANDARDS FOR HEALTH INSURANCE PLANS.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of a qualified association (as defined in section 183 of the Health Care Assurance Act of 1995), church plan (as defined in section 414(e) of the Internal Revenue Code of 1986), multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974), or plan maintained by a rural electric cooperative or a rural telephone cooperative association (within the meaning of section 3(40) of such Act) to comply with the requirements applicable to such association or plans under parts 1 and 2 of subtitle D of title I of the Health Care Assurance Act of 1995.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by a qualified association, church

plan, multiemployer plan, or plan maintained by a rural electric cooperative or a rural telephone cooperative association in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such a qualified association or plan.

''(b) AMOUNT OF TAX.—The amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each person to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the qualified association or plan.

''(d) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the first date the qualified association, church plan,

multiemployer plan, or plan maintained by a rural electric cooperative or a rural telephone cooperative association knows, or exercising reasonable diligence could have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.''.

(b) CLERICAL AMENDMENT.—The table of sections for such chapter 43, as amended by section 151, is amended by adding at the end the following new item:

''Sec. 4980D. Failure of qualified associations, etc., to comply with certain standards for health insurance plans.''.

# Subtitle E—1-Year Extension of Medicare Select

## SEC. 1011. 1-YEAR EXTENSION OF PERIOD FOR ISSUANCE OF MEDICARE SELECT POLICIES.

(a) IN GENERAL.—Section 4358(c) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1320c–3 note) is amended by striking ''3½-year'' and inserting ''4½-year''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1990.

# Subtitle F—Tax Provisions

## SEC. 1021. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) PHASE-IN DEDUCTION.—Section 162(*l*) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended—

(1) by striking paragraph (6); and

(2) by striking paragraph (1) and inserting the following:

''(1) ALLOWANCE OF DEDUCTION.—

''(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined as follows:

| "If the taxable year begins in: | The applicable percentage is: |
|---|---|
| 1994 or 1995 | 25 percent |
| 1996 or 1997 | 50 percent |
| 1998 or 1999 | 75 percent |
| 2000 or thereafter | 100 percent. |

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

**SEC. 1022. AMENDMENTS TO COBRA.**

(a) LOWER COST COVERAGE OPTIONS.—Subparagraph (A) of section 4980B(f)(2) of the Internal Revenue Code of 1986 (relating to continuation coverage requirements of group health plans) is amended to read as follows:

''(A) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided—

''(i) is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred,

''(ii) is so identical, except such coverage is offered with an annual $1,000 deductible, and

''(iii) is so identical, except such coverage is offered with an annual $3,000 deductible.

If coverage under the plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this subsection in connection with such group.''.

(b) TERMINATION OF COBRA COVERAGE AFTER ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90 DAYS.—Clause (iv) of section 4980B(f)(2)(B) of such Code (relating to period of coverage) is amended—

(1) by striking ''or'' at the end of subclause (I),

(2) by redesignating subclause (II) as subclause (III), and

(3) by inserting after subclause (I) the following new subclause:

''(II) eligible for such employer-based coverage for more than 90 days, or''.

(c) REDUCTION OF PERIOD OF COVERAGE.—Clause (i) of section 4980B(f)(2)(B) of such Code (relating to period of coverage) is amended by striking ''18 months'' each place it appears and inserting ''24 months''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring after the date of the enactment of this Act.

# TITLE II—PRIMARY AND PREVENTIVE CARE SERVICES

## SEC. 201. GRANTS TO STATES FOR HEALTHY START INITIATIVES.

(a) IN GENERAL.—The Secretary shall make grants to States with applications approved under this section in order to significantly reduce infant mortality and low birth weight births and improve the health and well-being of pregnant women, mothers, infants, and their families over a 5-year period through accelerated implementation of innovative strategies.

(b) PROJECTS DESCRIBED.—

(1) IN GENERAL.—In order to achieve the purposes described in subsection (a), grant funds under this section shall be used to conduct projects in eligible project areas (as defined in paragraph (3)). A project under this section shall be conducted by a community-based consortium (as defined in paragraph (4)) located in such eligible project area.

(2) CERTAIN ACTIVITIES.—A community-based consortium conducting a project under this section shall—

(A) have the ability to maximize and coordinate existing Federal, State, and local resources and acquire additional resources;

(B) ensure substantial involvement in State and local maternal and child health agencies and other agencies;

(C) have a demonstrated ability to effectively manage the project's fiscal resources;

(D) have the leadership capability to achieve the project goals and objectives; and

(E) target communities in which problems are most severe, resources can be concentrated, implementation is manageable, and progress can be measured.

(3) ELIGIBLE PROJECT AREA.—The term ''eligible project area'' means an area which is composed of one or more contiguous or noncontiguous geographic areas which have—

(A) an average annual infant mortality rate of 150 percent of the State's average annual infant mortality rate based upon an average of the most recently available official vital statistics data for the previous 5-year period; and

(B) at least 50 infant deaths per year, but not more than 200 infant deaths per year.

(4) COMMUNITY-BASED CONSORTIUM.—The term ''community-based consortium'' means a group

of project area providers and consumers, including public health departments, community and migrant health centers, hospitals, local professional associations, medical schools, grant-making foundations, civic groups, schools, churches, social and fraternal organizations, and residents of areas to be served.

(5) DURATION.—A project receiving funds under this section shall operate for no more than 5 years.

(c) APPLICATION.—

(1) IN GENERAL.—To be eligible to receive a grant under this section a State shall prepare and submit to the Secretary for approval an application at such time, in such manner, and containing such information, as the Secretary may require, including a description of the use to which the State will apply any amounts received under the grant and the information required under paragraph (3). A State may submit only one application under this subsection.

(2) APPLICATIONS ON BEHALF OF CONSORTIA.—Applications for grant funds shall be submitted under paragraph (1) on behalf of a community-based consortium located in an eligible project area. Such applications shall be approved by the highest

elected official of the city or county in which the consortium is based.

(3) INFORMATION REQUIRED.—The information required is a detailed description of the following:

(A) The extent to which the State has justified and documented the need for the project to be funded by the grant and developed measurable goals and objectives for meeting the need.

(B) The level of community commitment and involvement with the project.

(C) The extent to which the community-based consortium operating in the project area has demonstrated plans for coordinating and maximizing existing and proposed Federal, State, and local and private resources.

(D) The extent of the involvement of State and local providers of primary care and public health services in the project.

(E) The State's approach to planning for a public education campaign to address the maintenance of early and continuous prenatal care and of preventive health practices during pregnancy and infancy.

(F) Other factors which the Secretary determines will increase the potential of projects to reduce by 50 percent the rate of infant mortality.

(d) FUNDING.—

(1) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $150,000,000 for fiscal year 1996, $250,000,000 for fiscal year 1997, and $300,000,000 for fiscal years 1998 through 2001.

(2) DISTRIBUTION OF FUNDS.—

(A) IN GENERAL.—For a fiscal year, each State shall be allocated an amount equal to the applicable percentage determined under subparagraph (B) of the total amount available under this section for all States.

(B) APPLICABLE PERCENTAGE.—The applicable percentage for a State for a fiscal year is the amount (expressed as a percentage) equal to—

(i) the amount available to the State in the preceding fiscal year under title V of the Social Security Act; divided by

(ii) the total amount available to all States in the preceding fiscal year under such title.

**SEC. 202. REAUTHORIZATION OF CERTAIN PROGRAMS PROVIDING PRIMARY AND PREVENTIVE CARE.**

(a) IMMUNIZATION PROGRAMS.—Section 317(j)(1)(A) of the Public Health Service Act (42 U.S.C. 247b(j)(1)(A)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by striking ''each of the fiscal years 1992 through 1995'' and inserting ''each of the fiscal years 1992 through 1995, $600,000,000 for fiscal years 1996 and 1997, and such sums as may be necessary for each of the fiscal years 1998 through 2000''.

(b) TUBERCULOSIS PREVENTION GRANTS.—Section 317(j)(2) of the Public Health Service Act (42 U.S.C. 247b(j)(2)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by striking ''each of the fiscal years 1992 through 1995'' and inserting ''each of the fiscal years 1992 through 1995, $150,000,000 for fiscal

year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 1999''.

(c) SEXUALLY TRANSMITTED DISEASES.—Section 318(d)(1) of the Public Health Service Act (42 U.S.C. 247c(d)(1)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by inserting before the first period the following: ''$125,000,000 for fiscal years 1996 and 1997, and such sums as may be necessary for each of the fiscal years 1998 through 2000''.

(d) MIGRANT HEALTH CENTERS.—Section 329(h)(1)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(1)(A)) is amended by striking ''and 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1994'' and inserting ''through 1995, $80,000,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 1999''.

(e) COMMUNITY HEALTH CENTERS.—Section 330(g)(1)(A) of the Public Health Service Act (42 U.S.C. 254c(g)(1)(A)) is amended by striking ''and 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1994'' and inserting ''through 1995, $700,000,000 for fiscal year 1996, and such sums as may

be necessary for each of the fiscal years 1997 through 1999''.

(f) HEALTH CARE SERVICES FOR THE HOMELESS.—Section 340(q)(1) of the Public Health Service Act (42 U.S.C. 256(q)(1)) is amended—

(1) by striking ''and such'' and inserting ''such''; and

(2) by striking ''and 1994.'' and inserting ''through 1995, $90,000,000 for fiscal years 1996 and 1997, and such sums as may be necessary for each of the fiscal years 1998 through 2000.''.

(g) FAMILY PLANNING PROJECT GRANTS.—Section 1001(d) of the Public Health Service Act (42 U.S.C. 300(d)) is amended—

(1) by striking ''and $158,400,000'' and inserting ''$158,400,000''; and

(2) by inserting before the period the following: ''; $200,000,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 1999''.

(h) BREAST AND CERVICAL CANCER PREVENTION.—Section 1509(a) of the Public Health Service Act (42 U.S.C. 300n–5(a)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by striking ''for each of the fiscal years 1992 and 1993'' and inserting ''for each of the fiscal years 1992 through 1995, $100,000,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 1999''.

(i) PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT.—Section 1901(a) of the Public Health Service Act (42 U.S.C. 300w(a)) is amended by striking ''$205,000,000'' and inserting ''$235,000,000''.

(j) HIV EARLY INTERVENTION.—Section 2655 of the Public Health Service Act (42 U.S.C. 300ff–55) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by inserting before the period '', $650,000,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 1999''.

(k) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.—Section 501(a) of the Social Security Act (42 U.S.C. 701(a)) is amended by striking ''$705,000,000 for fiscal year 1994 and each fiscal year thereafter'' and inserting ''$705,000,000 for fiscal years 1994 and 1995, $800,000,000 for fiscal year 1996, and

such sums as may be necessary in each of the fiscal years 1997 through 1999''.

**SEC. 203. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.**

(a) PURPOSE.—It is the purpose of this section to establish a comprehensive school health education and prevention program for elementary and secondary school students.

(b) PROGRAM AUTHORIZED.—The Secretary of Education (referred to in this section as the ''Secretary''), through the Office of Comprehensive School Health Education established in subsection (e), shall award grants to States from allotments under subsection (c) to enable such States to—

(1) award grants to local or intermediate educational agencies, and consortia thereof, to enable such agencies or consortia to establish, operate, and improve local programs of comprehensive health education and prevention, early health intervention, and health education, in elementary and secondary schools (including preschool, kindergarten, intermediate, and junior high schools); and

(2) develop training, technical assistance, and coordination activities for the programs assisted pursuant to paragraph (1).

(c) RESERVATIONS AND STATE ALLOTMENTS.—

(1) RESERVATIONS.—From the sums appropriated pursuant to the authority of subsection (f) for any fiscal year, the Secretary shall reserve—

(A) 1 percent for payments to Guam, American Samoa, the Virgin Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, the Northern Mariana Islands, and the Republic of Palau, to be allotted in accordance with their respective needs; and

(B) 1 percent for payments to the Bureau of Indian Affairs.

(2) STATE ALLOTMENTS.—From the remainder of the sums not reserved under paragraph (1), the Secretary shall allot to each State an amount which bears the same ratio to the amount of such remainder as the school-age population of the State bears to the school-age population of all States, except that no State shall be allotted less than an amount equal to 0.5 percent of such remainder.

(3) REALLOTMENT.—The Secretary may reallot any amount of any allotment to a State to the extent that the Secretary determines that the State will not be able to obligate such amount within 2 years of al-

lotment. Any such reallotment shall be made on the same basis as an allotment under paragraph (2).

(d) USE OF FUNDS.—Grant funds provided to local or intermediate educational agencies, or consortia thereof, under this section may be used to improve elementary and secondary education in the areas of—

(1) personal health and fitness;

(2) prevention of chronic diseases;

(3) prevention and control of communicable diseases;

(4) nutrition;

(5) substance use and abuse;

(6) accident prevention and safety;

(7) community and environmental health;

(8) mental and emotional health;

(9) parenting and the challenges of raising children; and

(10) the effective use of the health services delivery system.

(e) OFFICE OF COMPREHENSIVE SCHOOL HEALTH EDUCATION.—The Secretary shall establish within the Office of the Secretary an Office of Comprehensive School Health Education which shall have the following responsibilities:

(1) To recommend mechanisms for the coordination of school health education programs conducted by the various departments and agencies of the Federal Government.

(2) To advise the Secretary on formulation of school health education policy within the Department of Education.

(3) To disseminate information on the benefits to health education of utilizing a comprehensive health curriculum in schools.

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $50,000,000 for fiscal year 1996 and such sums as may be necessary for each of the fiscal years 1997 and 1998 to carry out this section.

(2) AVAILABILITY.—Funds appropriated pursuant to the authority of paragraph (1) in any fiscal year shall remain available for obligation and expenditure until the end of the fiscal year succeeding the fiscal year for which such funds were appropriated.

**SEC. 204. COMPREHENSIVE EARLY CHILDHOOD HEALTH EDUCATION PROGRAM.**

(a) PURPOSE.—It is the purpose of this section to establish a comprehensive early childhood health education program.

(b) PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall conduct a program of awarding grants to agencies conducting Head Start training to enable such agencies to provide training and technical assistance to Head Start teachers and other child care providers. Such program shall—

(1) establish a training system through the Head Start agencies and organizations conducting Head Start training for the purpose of enhancing teacher skills and providing comprehensive early childhood health education curriculum;

(2) enable such agencies and organizations to provide training to day care providers in order to strengthen the skills of the early childhood workforce in providing health education;

(3) provide technical support for health education programs and curricula; and

(4) provide cooperation with other early childhood providers to ensure coordination of such pro-

grams and the transition of students into the public school environment.

(c) USE OF FUNDS.—Grant funds under this section may be used to provide training and technical assistance in the areas of—

(1) personal health and fitness;

(2) prevention of chronic diseases;

(3) prevention and control of communicable diseases;

(4) dental health;

(5) nutrition;

(6) substance use and abuse;

(7) accident prevention and safety;

(8) community and environmental health;

(9) mental and emotional health; and

(10) strengthening the role of parent involvement.

(d) RESERVATION FOR INNOVATIVE PROGRAMS.—The Secretary shall reserve 5 percent of the funds appropriated pursuant to the authority of subsection (e) in each fiscal year for the development of innovative model health education programs or curricula.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $40,000,000 for fiscal

year 1996 and such sums as may be necessary for each of the fiscal years 1997 and 1998 to carry out this section.

# TITLE III—PATIENT'S RIGHT TO DECLINE MEDICAL TREATMENT

**SEC. 301. PATIENT'S RIGHT TO DECLINE MEDICAL TREATMENT.**

(a) RIGHT TO DECLINE MEDICAL TREATMENT.—

(1) RIGHTS OF COMPETENT ADULTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a State may not restrict the right of a competent adult to consent to, or to decline, medical treatment.

(B) LIMITATIONS.—

(i) AFFECT ON THIRD PARTIES.—A State may impose limitations on the right of a competent adult to decline treatment if such limitations protect third parties (including minor children) from harm.

(ii) TREATMENT WHICH IS NOT MEDICALLY INDICATED.—Nothing in this subsection shall be construed to require that any individual be offered, or to state that any individual may demand, medical treatment which the health care provider does not have available, or which is, under pre-

vailing medical standards, either futile or otherwise not medically indicated.

(2) RIGHTS OF INCAPACITATED ADULTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B)(i) of paragraph (1), States may not restrict the right of an incapacitated adult to consent to, or to decline, medical treatment as exercised through the documents specified in this paragraph, or through similar documents or other written methods of directive which evidence the adult's treatment choices.

(B) ADVANCE DIRECTIVES AND POWERS OF ATTORNEY.—

(i) IN GENERAL.—In order to facilitate the communication, despite incapacity, of an adult's treatment choices, the Secretary, in consultation with the Attorney General, shall develop a national advance directive form that—

(I) shall not limit or otherwise restrict, except as provided in subparagraph (B)(i) of paragraph (1), an adult's right to consent to, or to decline, medical treatment; and

(II) shall, at minimum—

(aa) provide the means for an adult to declare such adult's own treatment choices in the event of a terminal condition;

(bb) provide the means for an adult to declare, at such adult's option, treatment choices in the event of other conditions which are medically incurable, and from which such adult likely will not recover; and

(cc) provide the means by which an adult may, at such adult's option, declare such adult's wishes with respect to all forms of medical treatment, including forms of medical treatment such as the provision of nutrition and hydration by artificial means which may be, in some circumstances, relatively nonburdensome.

(ii) NATIONAL DURABLE POWER OF ATTORNEY FORM.—The Secretary, in consultation with the Attorney General, shall

develop a national durable power of attorney form for health care decisionmaking. The form shall provide a means for any adult to designate another adult or adults to exercise the same decisionmaking powers which would otherwise be exercised by the patient if the patient were competent.

(iii) HONORED BY ALL HEALTH CARE PROVIDERS.—The national advance directive and durable power of attorney forms developed by the Secretary shall be honored by all health care providers.

(iv) LIMITATIONS.—No individual shall be required to execute an advance directive. This section makes no presumption concerning the intention of an individual who has not executed an advance directive. An advance directive shall be sufficient, but not necessary, proof of an adult's treatment choices with respect to the circumstances addressed in the advance directive.

(C) DEFINITION.—For purposes of this paragraph, the term ''incapacity'' means the inability to understand or to communicate con-

cerning the nature and consequences of a health care decision (including the intended benefits and foreseeable risks of, and alternatives to, proposed treatment options), and to reach an informed decision concerning health care.

(3) HEALTH CARE PROVIDERS.—

(A) IN GENERAL.—No health care provider may provide treatment to an adult contrary to the adult's wishes as expressed personally, by an advance directive as provided for in paragraph (2)(B), or by a similar written advance directive form or another written method of directive which clearly and convincingly evidence the adult's treatment choices. A health provider who acts in good faith pursuant to the preceding sentence shall be immune from criminal or civil liability or discipline for professional misconduct.

(B) HEALTH CARE PROVIDERS UNDER THE MEDICARE AND MEDICAID PROGRAMS.—Any health care provider who knowingly provides services to an adult contrary to the adult's wishes as expressed personally, by an advance directive as provided for in paragraph (2)(B), or by a similar written advance directive form

or another written method of directive which clearly and convincingly evidence the adult's treatment choices, shall be denied payment for such services under titles XVIII and XIX of the Social Security Act.

(C) TRANSFERS.—Health care providers who object to the provision of medical care in accordance with an adult's wishes shall transfer the adult to the care of another health care provider.

(4) DEFINITION.—For purposes of this subsection, the term ''adult'' means—

(A) an individual who is 18 years of age or older; or

(B) an emancipated minor.

(b) FEDERAL RIGHT ENFORCEABLE IN FEDERAL COURTS.—The rights recognized in this section may be enforced by filing a civil action in an appropriate district court of the United States.

(c) SUICIDE AND HOMICIDE.—Nothing in this section shall be construed to permit, condone, authorize, or approve suicide or mercy killing, or any affirmative act to end a human life.

(d) RIGHTS GRANTED BY STATES.—Nothing in this section shall impair or supersede rights granted by State law which exceed the rights recognized by this section.

(e) EFFECT ON OTHER LAWS.—

(1) IN GENERAL.—Except as specified in paragraph (2), written policies and written information adopted by health care providers pursuant to sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), shall be modified within 6 months after the enactment of this section to conform to the provisions of this section.

(2) DELAY PERIOD FOR UNIFORM FORMS.—Health care providers shall modify any written forms distributed as written information under sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) not later than 6 months after promulgation of the forms referred to in clauses (i) and (ii) of subsection (a)(2)(B) by the Secretary.

(f) INFORMATION PROVIDED TO CERTAIN INDIVIDUALS.—The Secretary shall provide on a periodic basis written information regarding an individual's right to consent to, or to decline, medical treatment as provided in

this section to individuals who are beneficiaries under titles II, XVI, XVIII, and XIX of the Social Security Act.

(g) RECOMMENDATIONS TO CONGRESS ON ISSUES RELATING TO A PATIENT'S RIGHT OF SELF-DETERMINATION.—Not later than 180 days after the date of the enactment of this Act, and annually thereafter for a period of 3 years, the Secretary shall provide recommendations to Congress concerning the medical, legal, ethical, social, and educational issues related to in this section. In developing recommendations under this subsection the Secretary shall address the following issues:

(1) The contents of the forms referred to in clauses (i) and (ii) of subsection (a)(2)(B).

(2) Issues pertaining to the education and training of health care professionals concerning patients' self-determination rights.

(3) Issues pertaining to health care professionals' duties with respect to patients' rights, and health care professionals' roles in identifying, assessing, and presenting for patient consideration medically indicated treatment options.

(4) Issues pertaining to the education of patients concerning their rights to consent to, and decline, treatment, including how individuals might best be informed of such rights prior to hospitaliza-

tion and how uninsured individuals, and individuals not under the regular care of a physician or another provider, might best be informed of their rights.

(5) Issues relating to appropriate standards to be adopted concerning decisionmaking by incapacitated adult patients whose treatment choices are not known.

(6) Such other issues as the Secretary may identify.

(h) EFFECTIVE DATE.—

(1) IN GENERAL.—This section shall take effect on the date that is 6 months after the date of enactment of this Act.

(2) SUBSECTION (g).—The provisions of subsection (g) shall take effect on the date of enactment of this Act.

# TITLE IV—PRIMARY AND PREVENTIVE CARE PROVIDERS

## SEC. 401. EXPANDED COVERAGE OF CERTAIN NONPHYSICIAN PROVIDERS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(1) in subparagraph (K), by striking ''80 percent'' and all that follows through ''physician)'' and

inserting ''85 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician''; and

(2) by amending subparagraph (O) to read as follows: ''(O) with respect to services described in section 1861(s)(2)(K) (relating to services provided by a nurse practitioner, clinical nurse specialist, or physician assistant) the amounts paid shall be 85 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician, and''.

(b) NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Section 1842(b)(12) of the Social Security Act (42 U.S.C. 1395u(b)(12)) is amended to read as follows:

''(12) With respect to services described in clause (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners)—

''(A) payment under this part may only be made on an assignment-related basis; and

''(B) the prevailing charges determined under paragraph (3) shall not exceed—

''(i) in the case of services performed as an assistant at surgery, 85 percent of the amount that would otherwise be recognized if performed

by a physician who is serving as an assistant at surgery, or

''(ii) in other cases, 85 percent of the fee schedule amount specified in section 1848 for such services performed by physicians who are not specialists.''.

(c) DIRECT PAYMENT FOR ALL NURSE PRACTITIONERS OR CLINICAL NURSE SPECIALISTS.—(1) Section 1832(a)(2)(B)(iv) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking ''provided in a rural area (as defined in section 1886(d)(2)(D))''.

(2) Subparagraph (C) of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended by striking ''shall'' and inserting ''may''.

(d) REMOVAL OF RESTRICTIONS ON SETTINGS.—Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (i), by striking ''(I) in a hospital'' and all that follows through ''professional shortage area,'';

(2) in clause (ii), by striking ''in a skilled'' and all that follows through ''1919(a)''; and

(3) in clause (iii), by striking ''in a rural'' and all that follows through ''(d)(2)(D))''.

**SEC. 402. REQUIRING COVERAGE OF CERTAIN NONPHYSICIAN PROVIDERS UNDER THE MEDICAID PROGRAM.**

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (24),

(2) by redesignating paragraph (25) as paragraph (26), and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) services furnished by a physician assistant, nurse practitioner, clinical nurse specialist (as defined in section 1861(aa)(5)), and certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and''.

**SEC. 403. MEDICAL STUDENT TUTORIAL PROGRAM GRANTS.**

Part C of title VII of the Public Health Service Act is amended by adding at the end thereof the following new section:

**''SEC. 753. MEDICAL STUDENT TUTORIAL PROGRAM GRANTS.**

''(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible schools of medicine or osteopathic medicine to enable such schools to pro-

vide medical students for tutorial programs or as participants in clinics designed to interest high school or college students in careers in general medical practice.

''(b) APPLICATION.—To be eligible to receive a grant under this section, a school of medicine or osteopathic medicine shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including assurances that the school will use amounts received under the grant in accordance with subsection (c).

''(c) USE OF FUNDS.—

''(1) IN GENERAL.—Amounts received under a grant awarded under this section shall be used to—

''(A) fund programs under which students of the grantee are provided as tutors for high school and college students in the areas of mathematics, science, health promotion and prevention, first aide, nutrition and prenatal care;

''(B) fund programs under which students of the grantee are provided as participants in clinics and seminars in the areas described in paragraph (1); and

''(C) conduct summer institutes for high school and college students to promote careers in medicine.

''(2) DESIGN OF PROGRAMS.—The programs, institutes, and other activities conducted by grantees under paragraph (1) shall be designed to—

''(A) give medical students desiring to practice general medicine access to the local community;

''(B) provide information to high school and college students concerning medical school and the general practice of medicine; and

''(C) promote careers in general medicine.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 1996, and such sums as may be necessary for fiscal year 1997.''.

**SEC. 404. GENERAL MEDICAL PRACTICE GRANTS.**

Part C of title VII of the Public Health Service Act (as amended by section 403) is further amended by adding at the end thereof the following new section:

**"SEC. 754. GENERAL MEDICAL PRACTICE GRANTS.**

''(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible public or private nonprofit schools of medicine or osteopathic medicine, hos-

pitals, residency programs in family medicine or pediatrics, or to a consortium of such entities, to enable such entities to develop effective strategies for recruiting medical students interested in the practice of general medicine and placing such students into general practice positions upon graduation.

''(b) APPLICATION.—To be eligible to receive a grant under this section, an entity of the type described in subsection (a) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including assurances that the entity will use amounts received under the grant in accordance with subsection (c).

''(c) USE OF FUNDS.—Amounts received under a grant awarded under this section shall be used to fund programs under which effective strategies are developed and implemented for recruiting medical students interested in the practice of general medicine and placing such students into general practice positions upon graduation.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $25,000,000 for each of the fiscal years 1996 through 2000, and such sums as may be necessary for fiscal years thereafter.''.

# TITLE V—COST CONTAINMENT

**SEC. 501. NEW DRUG CLINICAL TRIALS PROGRAM.**

Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following new section:

**"SEC. 409B. NEW DRUG CLINICAL TRIALS PROGRAM.**

''(a) IN GENERAL.—The Director of the National Institutes of Health (referred to in this section as the 'Director') is authorized to establish and implement a program for the conduct of clinical trials with respect to new drugs and disease treatments determined to be promising by the Director. In determining the drugs and disease treatments that are to be the subject of such clinical trials, the Director shall give priority to those drugs and disease treatments targeted toward the diseases determined—

''(1) to be the most costly to treat;

''(2) to have the highest mortality; or

''(3) to affect the greatest number of individuals.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $120,000,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 2000.''.

**SEC. 502. MEDICAL TREATMENT EFFECTIVENESS.**

(a) RESEARCH ON COST-EFFECTIVE METHODS OF HEALTH CARE.—Section 926 of the Public Health Service Act (42 U.S.C. 299c–5) is amended—

(1) in subsection (a), by striking ''and'' and inserting ''and such sums as may be necessary for each of the fiscal years 1996 through 1998''; and

(2) by adding at the end the following new subsection:

''(f) USE OF ADDITIONAL APPROPRIATIONS.—Within amounts appropriated under subsection (a) for each of the fiscal years 1995 through 1997 that are in excess of the amounts appropriated under such subsection for fiscal year 1993, the Secretary shall give priority to expanding research conducted to determine the most cost-effective methods of health care and for developing and disseminating new practice guidelines related to such methods. In utilizing such amounts, the Secretary shall give priority to diseases and disorders that the Secretary determines are the most costly to the United States and evidence a wide variation in current medical practice.''.

(b) RESEARCH ON MEDICAL TREATMENT OUTCOMES.—

(1) IMPOSITION OF TAX ON HEALTH INSURANCE POLICIES.—

(A) IN GENERAL.—Chapter 36 of the Internal Revenue Code of 1986 (relating to certain other excise taxes) is amended by adding at the end thereof the following new subchapter:

## ''Subchapter G—Tax on Health Insurance Policies



**''SEC. 4501. IMPOSITION OF TAX.**

''(a) GENERAL RULE.—There is hereby imposed a tax equal to .001 cent on each dollar, or fractional part thereof, of the premium paid on a policy of health insurance.

''(b) DEFINITION.—For purposes of subsection (a), the term 'policy of health insurance' means any policy or other instrument by whatever name called whereby a contract of insurance is made, continued, or renewed with respect to the health of an individual or group of individuals.

**''SEC. 4502. LIABILITY FOR TAX.**

''The tax imposed by this subchapter shall be paid, on the basis of a return, by any person who makes, signs, issues, or sells any of the documents and instruments subject to the tax, or for whose use or benefit the same are made, signed, issued, or sold. The United States or any agency or instrumentality thereof shall not be liable for the tax.''.

(B) CONFORMING AMENDMENT.—The table of subchapters for chapter 36 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new item:

''SUBCHAPTER G. Tax on health insurance policies.''.

(2) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of such Code (relating to trust fund code) is amended by adding at the end thereof the following new section:

**''SEC. 9512. TRUST FUND FOR MEDICAL TREATMENT OUTCOMES RESEARCH.**

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Trust Fund for Medical Treatment Outcomes Research' (referred to in this section as the 'Trust Fund'), consisting of such amounts as may be appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

''(b) TRANSFERS TO TRUST FUND.—There is hereby appropriated to the Trust Fund an amount equivalent to the taxes received in the Treasury under section 4501 (relating to tax on health insurance policies).

''(c) DISTRIBUTION OF AMOUNTS IN TRUST FUND.—On an annual basis the Secretary shall distribute the amounts in the Trust Fund to the Secretary of Health

and Human Services. Such amounts shall be available to the Secretary of Health and Human Services to pay for research activities related to medical treatment outcomes.''.

(B) CONFORMING AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end thereof the following new item:

''Sec. 9512. Trust Fund for Medical Treatment Outcomes Research.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to policies issued after December 31, 1995.

**SEC. 503. NATIONAL HEALTH INSURANCE DATA AND CLAIMS SYSTEM.**

(a) IN GENERAL.—Using advanced technologies to the maximum extent practicable, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish and maintain a national health insurance data and claims system, which shall be comprised of—

(1) a centralized national data base for health insurance and health outcomes information;

(2) a standardized, universal mechanism for electronically processing health insurance and health outcomes data; and

(3) a standardized system for uniform claims and uniform transmission of claims.

(b) NATIONAL DATA BASE FOR HEALTH INSURANCE INFORMATION.—The national data base for health insurance and health outcomes information shall—

(1) be centrally located;

(2) rely on advanced technologies to the maximum extent practicable; and

(3) be readily accessible for data input and retrieval.

(c) STANDARDIZED SYSTEM FOR UNIFORM CLAIMS AND TRANSMISSION OF CLAIMS.—

(1) CONSULTATION WITH THE NAIC.—The Secretary shall consult with the National Association of Insurance Commissioners in connection with the establishment of the system under subsection (a)(3).

(2) USE OF RECOGNIZED STANDARDS.—The Secretary shall, to the maximum extent practicable, establish standards for the system under subsection (a)(3) that are consistent with standards that are widely recognized and adopted.

(3) TIMING FOR ESTABLISHMENT OF SYSTEM.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this

Act, the Secretary shall establish standards for the system under subsection (a)(3).

(B) REVIEW.—Not later than 24 months after standards have been established under subparagraph (A), the Secretary shall review such standards and make any modifications determined appropriate by the Secretary.

(d) CONFIDENTIALITY.—The Secretary shall ensure that all patient information collected under this section is managed so that confidentiality is protected.

(e) AUTHORIZATION OF APPROPRIATIONS.—There shall be authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

**SEC. 504. HEALTH CARE COST CONTAINMENT AND QUALITY INFORMATION PROGRAM.**

(a) GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall make grants to States that establish or operate health care cost containment and quality information systems (as defined in subsection (f)(1)). In order to be eligible for a grant under this section, a State must establish or operate a system which, at a minimum, meets the Federal standards established under subsection (c).

(2) USE OF FUNDS.—States may use grant funds received under this section only to establish a health care cost containment and quality information system or to improve an existing system operated by the State.

(b) SUBMISSION OF APPLICATIONS.—To be eligible for a grant under this section, a State must submit an application to the Secretary within 2 years after the date of the enactment of this section. Such application shall be submitted in a manner determined appropriate by the Secretary and shall include the designation of a State agency that will operate the health care cost containment and quality information system for the State. The Secretary shall approve or disapprove a State application within 6 months after its submission.

(c) MINIMUM FEDERAL STANDARDS.—Not later than 6 months after the date of the enactment of this section, the Secretary, after consultation with the Agency for Health Care Policy and Research, other Federal agencies, the Joint Commission on Accreditation of Hospitals, States, health care providers, consumers, insurers, health maintenance organizations, businesses, academic health centers, and labor organizations that purchase health care, shall establish Federal standards for the operation of

health care cost containment and quality information systems by States receiving grants under this section.

(d) COLLECTION AND PUBLIC DISSEMINATION OF INFORMATION BY STATES.—

(1) IN GENERAL.—A State receiving a grant under this section shall require that a health care cost containment and quality information system will collect at least the information described in paragraph (2) and publicly disseminate such information in a useful format to appropriate persons such as businesses, consumers of health care services, labor organizations, health plans, hospitals, and other States.

(2) INFORMATION DESCRIBED.—The information described in this paragraph is the following:

(A) Information on hospital charges.

(B) Clinical data.

(C) Demographic data.

(D) Information regarding treatment of individuals by particular health care providers.

(3) ELECTRONIC TRANSMISSION OF INFORMATION.—The State program under this section shall provide that any information described in paragraph (2) with respect to which the Secretary has established standards for data elements and information

transactions under section 503 shall be transmitted to the State health care cost containment and quality information system in accordance with such standards.

(4) PRIVACY AND CONFIDENTIALITY.—The State cost containment and quality information system shall ensure that patient privacy and confidentiality is protected at all times.

(e) COMPLIANCE.—If the Secretary determines that a State receiving grant funds under this section has failed to operate a system in accordance with the terms of its approved application, the Secretary may withhold payment of such funds until the State remedies such noncompliance.

(f) DEFINITIONS.—For purposes of this section—

(1) the term ''health care cost containment and quality information system'' means a system which is established or operated by a State in order to collect and disseminate the information described in subsection (d)(2) in accordance with subsection (d)(1) for the purpose of providing information on health care costs and outcomes in the State; and

(2) the term ''State'' means a State, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa,

and includes the Commonwealth of the Northern Mariana Islands.

(g) AUTHORIZATION.—

(1) IN GENERAL.—There are authorized to be appropriated for the purpose of carrying out this section not more than $150,000,000 for fiscal years 1996 through 1998, and such sums as may be necessary thereafter, to remain available until expended.

(2) ALLOCATION TO STATES.—The Secretary shall allocate the amounts available for grants under this section in any fiscal year in accordance with a formula developed by the Secretary which takes into account—

(A) the number of hospitals in a State relative to the total number of hospitals in all States;

(B) the population of the State relative to the total population of all States; and

(C) the type of system operated or intended to be operated by the State, including whether the State establishes an independent State agency to operate the system.

# TITLE VI—LONG-TERM CARE

## Subtitle A—Tax Treatment of Qualified Long-Term Care Insurance Policies and Services

### SEC. 601. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

### SEC. 602. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in subsection (g)), or''.

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to the deduction for medical, dental, etc., expenses) is amended by adding at the end the following new subsections:

''(g) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, curing, mitigating, treating, preventive, therapeutic, and rehabilitative services, and maintenance and personal care services (whether performed in a residential or nonresidential setting) which—

''(A) are required by an individual during any period the individual is an incapacitated individual (as defined in paragraph (2)),

''(B) have as their primary purpose—

''(i) the provision of needed assistance with 1 or more activities of daily living (as defined in paragraph (3)), or

''(ii) protection from threats to health and safety due to severe cognitive impairment, and

''(C) are provided pursuant to a continuing plan of care prescribed by a licensed professional (as defined in paragraph (4)).

''(2) INCAPACITATED INDIVIDUAL.—The term 'incapacitated individual' means any individual who—

''(A) is unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), at least 2 activities of daily living as defined in paragraph (3), or

''(B) has severe cognitive impairment as defined by the Secretary in consultation with the Secretary of Health and Human Services.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless a licensed professional within the preceding 12-month period has certified that such individual meets such requirements.

''(3) ACTIVITIES OF DAILY LIVING.—Each of the following is an activity of daily living:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(4) LICENSED PROFESSIONAL.—The term 'licensed professional' means—

''(A) a physician or registered professional nurse, or

''(B) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

''(5) CERTAIN SERVICES NOT INCLUDED.—The term 'qualified long-term care services' shall not include any services provided to an individual—

''(A) by a relative (directly or through a partnership, corporation, or other entity) unless the relative is a licensed professional with respect to such services, or

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in paragraphs (1) through (8) of section 152(a).

''(h) SPECIAL RULE FOR CERTAIN LONG-TERM CARE EXPENSES.—For purposes of subsection (a), the term 'dependent' shall include any parent or grandparent of the taxpayer for whom the taxpayer has expenses for qualified long-term care services described in subsection (g), but only to the extent of such expenses.''.

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended to read as follows:

''(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in—

''(i) subparagraphs (A) and (B), or

''(ii) subparagraph (C), but only if such insurance is provided under a qualified long-term care insurance policy (as defined in section 7705(a)) and the amount paid for such insurance is not disallowed under section 7705(b).''

(2) Paragraph (6) of section 213(d) is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraph (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

**SEC. 603. DEFINITION OF QUALIFIED LONG-TERM CARE INSURANCE POLICY.**

(a) IN GENERAL.—Chapter 79 (relating to definitions) is amended by adding at the end the following new section:

**"SEC. 7705. QUALIFIED LONG-TERM CARE INSURANCE POLICY.**

''(a) QUALIFIED LONG-TERM CARE INSURANCE POLICY.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance policy' means any long-term care policy that—

''(A) limits benefits under such policy to individuals who are certified by a licensed professional (as defined in section 213(g)(4)) within the preceding 12-month period—

''(i) as being unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), 2 or more activities of daily living (as defined in section 213(g)(3)), or

''(ii) having a severe cognitive impairment (as defined in section 213(g)(2)(B)), and

''(B) satisfies the requirements of paragraphs (2), (3), (4), (5), and (6).

''(2) PREMIUM REQUIREMENTS.—The requirements of this paragraph are met with respect to a policy if such policy provides that premium payments may not be made earlier than the date such payments would have been made if the contract provided for level annual payments over the life expectancy of the insured or 20 years, whichever is shorter. A policy shall not be treated as failing to meet the requirements of the preceding sentence solely by reason of a provision in the policy providing for a waiver of premiums if the insured becomes an individual certified in accordance with paragraph (1)(A).

''(3) PROHIBITION OF CASH VALUE.—The requirements of this paragraph are met if the policy does not provide for a cash value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed, other than as provided in paragraph (4).

''(4) REFUNDS OF PREMIUMS AND DIVIDENDS.—The requirements of this paragraph are

met with respect to a policy if such policy provides that—

''(A) policyholder dividends are required to be applied as a reduction in future premiums or, to the extent permitted under paragraph (6), to increase benefits described in subsection (a)(2),

''(B) refunds of premiums upon a partial surrender or a partial cancellation are required to be applied as a reduction in future premiums, and

''(C) any refund on the death of the insured, or on a complete surrender or cancellation of the policy, cannot exceed the aggregate premiums paid under the contract.

Any refund on a complete surrender or cancellation of the policy shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

''(5) COORDINATION WITH OTHER ENTITLEMENTS.—The requirements of this paragraph are met with respect to a policy if such policy does not pay, or provide reimbursement for, expenses incurred to the extent that such expenses are also paid or reimbursed under title XVIII of the Social Secu-

rity Act or are paid or reimbursed under a qualified health insurance plan (as defined in section 100(10) of the Health Care Assurance Act of 1995).

''(6) MAXIMUM BENEFIT.—

''(A) IN GENERAL.—The requirements of this paragraph are met if the benefits payable under the policy for any period (whether on a periodic basis or otherwise) may not exceed the dollar amount in effect for such period.

''(B) NONREIMBURSEMENT PAYMENTS PERMITTED.—Benefits shall include all payments described in subsection (a)(2) to or on behalf of an insured individual without regard to the expenses incurred during the period to which the payments relate. For purposes of section 213(a), such payments shall be treated as compensation for expenses paid for medical care.

''(C) DOLLAR AMOUNT.—The dollar amount in effect under this paragraph shall be $150 per day (or the equivalent amount within the calendar year in the case of payments on other than a per diem basis).

''(D) ADJUSTMENTS FOR INCREASED COSTS.—

''(i) IN GENERAL.—In the case of any calendar year after 1996, the dollar amount in effect under subparagraph (C) for any period or portion thereof occurring during such calendar year shall be equal to the sum of—

''(I) the amount in effect under subparagraph (C) for the preceding calendar year (after application of this subparagraph), plus

''(II) the product of the amount referred to in subclause (I) multiplied by the cost-of-living adjustment for the calendar year.

''(ii) COST-OF-LIVING ADJUSTMENT.—For purposes of clause (i), the cost-of-living adjustment for any calendar year is the percentage (if any) by which the cost index under clause (iii) for the preceding calendar year exceeds such index for the second preceding calendar year.

''(iii) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1997, establish a cost index to measure

increases in costs of nursing home and similar facilities. The Secretary may from time to time revise such index to the extent necessary to accurately measure increases or decreases in such costs.

''(iv) SPECIAL RULE FOR CALENDAR YEAR 1997.—Notwithstanding clause (ii), for purposes of clause (i), the cost-of-living adjustment for calendar year 1997 is the sum of 1.5 percent plus the percentage by which the CPI for calendar year 1996 (as defined in section 1(f)(4)) exceeds the CPI for calendar year 1995 (as so defined).

''(E) PERIOD.—For purposes of this paragraph, a period begins on the date that an individual has a condition which would qualify for certification under subsection (b)(1)(A) and ends on the earlier of the date upon which—

''(i) such individual has not been so certified within the preceding 12-months, or

''(ii) the individual's condition ceases to be such as to qualify for certification under subsection (b)(1)(A).

''(F) AGGREGATION RULE.—For purposes of this paragraph, all policies issued with respect to the same insured shall be treated as one policy.

''(b) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—No deduction shall be allowed under section 213(a) for charges against a life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)), unless such charges are includible in income as a result of the application of section 72(e)(10) and the coverage provided by the rider is a qualified long-term care insurance policy under subsection (a).''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7704 the following new item:

''Sec. 7705. Qualified long-term care insurance.''.

**SEC. 604. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE AS ACCIDENT AND HEALTH INSURANCE FOR PURPOSES OF TAXATION OF INSURANCE COMPANIES.**

(a) IN GENERAL.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT OR HEALTH INSURANCE.—For

purposes of this subchapter, any reference to noncancellable accident or health insurance contracts shall be treated as including a reference to qualified long-term care insurance.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1995.

**SEC. 605. TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.**

(a) EXCLUSION OF AMOUNTS RECEIVED.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount paid to an individual under a life insurance contract on the life of an insured who is a terminally ill individual, who has a dread disease, or who has been permanently confined to a nursing home shall be treated as an amount paid by reason of the death of such insured.

''(2) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who has been certified by a physician, licensed under State law, as having

an illness or physical condition which can reasonably be expected to result in death in 12 months or less.

''(3) DREAD DISEASE.—For purposes of this subsection, the term 'dread disease' means a medical condition which has been certified by a physician as having required or requiring extraordinary medical intervention without which the insured would die, or a medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span.

''(4) PERMANENTLY CONFINED TO A NURSING HOME.—For purposes of this subsection, an individual has been permanently confined to a nursing home if the individual is presently confined to a nursing home and has been certified by a physician, licensed under State law, as having an illness or cognitive impairment or loss of functional capacity which can reasonably be expected to result in the individual remaining in a nursing home for the rest of the individual's life.''.

(b) TREATMENT OF QUALIFIED ACCELERATED DEATH BENEFIT RIDERS AS LIFE INSURANCE.—

(1) IN GENERAL.—Section 818 (relating to other definitions and special rules), as amended by

section 603, is amended by adding at the end the following new subsection:

''(h) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDER.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider or addendum on, or other provision of, a life insurance contract which provides for payments to an individual on the life of an insured upon such insured becoming a terminally ill individual (as defined in section 101(g)(2)), incurring a dread disease (as defined in section 101(g)(3)), or being permanently confined to a nursing home (as defined in section 101(g)(4)).''.

(2) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—

(A) RIDER TREATED AS QUALIFIED ADDITIONAL BENEFIT.—Subparagraph (A) of section 7702(f)(5) (relating to definition of life in-

surance contract) is amended by striking ''or'' at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

''(v) any qualified accelerated death benefit rider (as defined in section 818(h)(2)), or any qualified long-term care insurance which reduces the death benefit, or''.

(B) TRANSITIONAL RULE.—For purposes of applying section 7702 or 7702A of the Internal Revenue Code of 1986 to any contract (or determining whether either such section applies to such contract), the issuance of a rider or addendum on, or other provision of, a life insurance contract permitting the acceleration of death benefits (as described in section 101(g)) or for qualified long-term care insurance shall not be treated as a modification or material change of such contract.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

# Subtitle B—Tax Incentives for Purchase of Qualified Long-Term Care Insurance

**SEC. 611. CREDIT FOR QUALIFIED LONG-TERM CARE PREMIUMS.**

(a) GENERAL RULE.—Subpart C of part IV of subchapter A of chapter 1 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

**"SEC. 35. LONG-TERM CARE INSURANCE CREDIT.**

''(a) GENERAL RULE.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the premiums for a qualified long-term care insurance policy (as defined in section 7705(a)) paid during such taxable year for such individual or the spouse of such individual.

''(b) APPLICABLE PERCENTAGE.—

''(1) IN GENERAL.—For purposes of this section, the term 'applicable percentage' means 28 percent reduced (but not below zero) by 1 percentage point for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income for the taxable year exceeds the base amount.

''(2) BASE AMOUNT.—For purposes of paragraph (1) the term 'base amount' means—

''(A) except as otherwise provided in this paragraph, $25,000,

''(B) $40,000 in the case of a joint return, and

''(C) zero in the case of a taxpayer who—

''(i) is married at the close of the taxable year (within the meaning of section 7703) but does not file a joint return for such taxable year, and

''(ii) does not live apart from his or her spouse at all times during the taxable year.

''(c) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Any amount allowed as a credit under this section shall not be taken into account under section 213.''.

(b) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 is amended by striking the item relating to section 35 and inserting the following:

''Sec. 35. Long-term care insurance credit.
''Sec. 36. Overpayments of tax.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

**SEC. 612. EXCLUSION FROM GROSS INCOME OF BENEFITS RECEIVED UNDER QUALIFIED LONG-TERM CARE INSURANCE POLICIES.**

(a) IN GENERAL.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(j) SPECIAL RULES RELATING TO QUALIFIED LONG-TERM CARE INSURANCE POLICY.—For purposes of section 104, this section, and section 106—

''(1) BENEFITS TREATED AS PAYABLE FOR SICKNESS, ETC.—Any benefit received through a qualified long-term care insurance policy shall be treated as amounts received through accident or health insurance for personal injuries or sickness.

''(2) EXPENSES FOR WHICH REIMBURSEMENT PROVIDED UNDER QUALIFIED LONG-TERM CARE INSURANCE POLICY TREATED AS INCURRED FOR MEDICAL CARE OR FUNCTIONAL LOSS.—

''(A) EXPENSES.—Expenses incurred by the taxpayer or spouse, or by the dependent, parent, or grandparent of either, to the extent of benefits paid under a qualified long-term

care insurance policy shall be treated for purposes of subsection (b) as incurred for medical care (as defined in section 213(d)).

''(B) BENEFITS.—Benefits received under a qualified long-term care insurance policy shall be treated for purposes of subsection (c) as payment for the permanent loss or loss of use of a member or function of the body or the permanent disfigurement of the taxpayer or spouse, or the dependent, parent, or grandparent of either.

''(3) REFERENCES TO ACCIDENT AND HEALTH PLANS.—Any reference to an accident or health plan shall be treated as including a reference to a plan providing qualified long-term care services (as defined in section 213(a)).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1995.

**SEC. 613. EMPLOYER DEDUCTION FOR CONTRIBUTIONS MADE FOR LONG-TERM CARE INSURANCE.**

(a) IN GENERAL.—Subparagraph (B) of section 404(b)(2) (relating to plans providing certain deferred benefits) is amended to read as follows:

''(B) EXCEPTIONS.—Subparagraph (A) shall not apply to—

''(i) any benefit provided through a welfare benefit fund (as defined in section 419(e)), or

''(ii) any benefit provided under a qualified long-term care insurance policy through the payment (in whole or in part) of premiums for such policy by an employer pursuant to a plan for its active or retired employees, but only if any refund or premium is applied to reduce the future costs of the plan or increase benefits under the plan.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1995.

**SEC. 614. INCLUSION OF QUALIFIED LONG-TERM CARE INSURANCE IN CAFETERIA PLANS.**

(a) IN GENERAL.—Paragraph (2) of section 125(d) (relating to the exclusion of deferred compensation) is amended by adding at the end the following new subparagraph:

''(D) EXCEPTION FOR QUALIFIED LONG-TERM CARE INSURANCE POLICIES.—For pur-

poses of subparagraph (A), amounts paid or incurred for any qualified long-term care insurance policy shall not be treated as deferred compensation to the extent section 404(b)(2)(A) does not apply to such amounts by reason of section 404(b)(2)(B)(ii).''.

(b) CONFORMING AMENDMENT.—Subsection (f) of section 125 (relating to qualified benefits) is amended by striking ''and such term includes'' and inserting the following: '', qualified long-term care insurance policies, and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

**SEC. 615. EXCLUSION FROM GROSS INCOME FOR AMOUNTS RECEIVED ON CANCELLATION OF LIFE INSURANCE POLICIES AND USED FOR QUALIFIED LONG-TERM CARE INSURANCE POLICIES.**

(a) IN GENERAL.—

(1) EXCLUSION FROM GROSS INCOME.—

(A) IN GENERAL.—Part III of subchapter B of chapter 1 (relating to items specifically excluded from gross income) is amended by redesignating section 136 as section 137 and by in-

serting after section 135 the following new section:

**"SEC. 136. AMOUNTS RECEIVED ON CANCELLATION, ETC. OF LIFE INSURANCE CONTRACTS AND USED TO PAY PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE.**

''No amount (which but for this section would be includible in the gross income of an individual) shall be included in gross income on the whole or partial surrender, cancellation, or exchange of any life insurance contract during the taxable year if—

''(1) such individual has attained age 59½ on or before the date of the transaction, and

''(2) the amount otherwise includible in gross income is used during such year to pay for any qualified long-term care insurance policy which—

''(A) is for the benefit of such individual or the spouse of such individual if such spouse has attained age 59½ on or before the date of the transaction, and

''(B) may not be surrendered for cash.''.

(B) CLERICAL AMENDMENT.—The table of sections for such part III is amended by striking the last item and inserting the following new items:

(2) CERTAIN EXCHANGES NOT TAXABLE.—Subsection (a) of section 1035 (relating to certain exchanges of insurance contracts) is amended by striking the period at the end of paragraph (3) and inserting ''; or'', and by adding at the end the following new paragraph:

''(4) in the case of an individual who has attained age 59½, a contract of life insurance or an endowment or annuity contract for a qualified long-term care insurance policy, if such policy may not be surrendered for cash.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

**SEC. 616. USE OF GAIN FROM SALE OF PRINCIPAL RESIDENCE FOR PURCHASE OF QUALIFIED LONG-TERM HEALTH CARE INSURANCE.**

(a) IN GENERAL.—Subsection (d) of section 121 (relating to 1-time exclusion of gain from sale of principal residence by individual who has attained age 55) is amended by adding at the end the following new paragraph:

''(10) ELIGIBILITY OF HOME EQUITY CONVERSION SALE-LEASEBACK TRANSACTION FOR EXCLUSION.—

''(A) IN GENERAL.—For purposes of this section, the term 'sale or exchange' includes a home equity conversion sale-leaseback transaction.

''(B) HOME EQUITY CONVERSION SALE-LEASEBACK TRANSACTION.—For purposes of subparagraph (A), the term 'home equity conversion sale-leaseback' means a transaction in which—

''(i) the seller-lessee—

''(I) has attained the age of 55 before the date of the transaction,

''(II) sells property which during the 5-year period ending on the date of the transaction has been owned and used as a principal residence by such seller-lessee for periods aggregating 3 years or more,

''(III) uses a portion of the proceeds from such sale to purchase a qualified long-term care insurance pol-

icy, which policy may not be surrendered for cash,

''(IV) obtains occupancy rights in such property pursuant to a written lease requiring a fair rental, and

''(V) receives no option to repurchase the property at a price less than the fair market price of the property unencumbered by any leaseback at the time such option is exercised, and

''(ii) the purchaser-lessor—

''(I) is a person,

''(II) is contractually responsible for the risks and burdens of ownership and receives the benefits of ownership (other than the seller-lessee's occupancy rights) after the date of such transaction, and

''(III) pays a purchase price for the property that is not less than the fair market price of such property encumbered by a leaseback, and taking into account the terms of the lease.

''(C) ADDITIONAL DEFINITIONS.—For purposes of subparagraph (B)—

''(i) OCCUPANCY RIGHTS.—The term 'occupancy rights' means the right to occupy the property for any period of time, including a period of time measured by the life of the seller-lessee on the date of the sale-leaseback transaction (or the life of the surviving seller-lessee, in the case of jointly held occupancy rights), or a periodic term subject to a continuing right of renewal by the seller-lessee (or by the surviving seller-lessee, in the case of jointly held occupancy rights).

''(ii) FAIR RENTAL.—The term 'fair rental' means a rental for any subsequent year which equals or exceeds the rental for the first year of a sale-leaseback transaction.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to sales after December 31, 1995, in taxable years beginning after such date.

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S 18 IS——3

S 18 IS——4

S 18 IS——5

S 18 IS——6

S 18 IS——7

S 18 IS——8

S 18 IS——9

S 18 IS——10